CITY OF FORT LAUDERDALE

2020 BENEFITS HANDBOOK

WE BUILD COMMUNITY

All-America City

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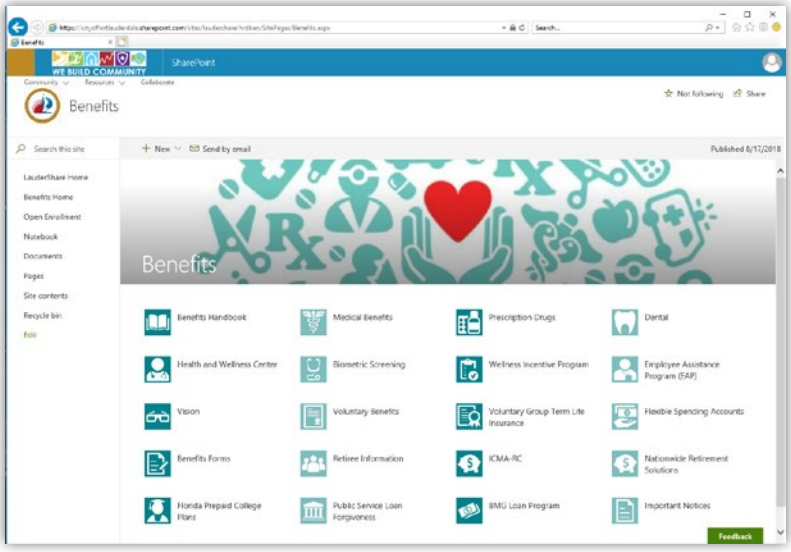
WE BUILD COMMUNITY

All-America City

The City of Fort Lauderdale offers eligible employees a comprehensive benefits package that includes medical, dental, vision, life insurance, health care and dependent care flex spending accounts, long-term disability, wellness initiatives, retirement plans and a variety of voluntary benefits. The information included in this Handbook is a general summary of available options and also serves to increase your awareness of policies and procedures. If any information in this Handbook conflicts with governing plan documents, certificates of coverage, City resolutions, or state/federal laws, the provisions of the governing plan documents, certificates of coverage, City resolutions and state/federal laws will prevail.

Please also take the time to review the Benefits web page for Frequently Asked Questions, important notices, plan certificates of coverage, available forms, any updates subsequent to printing this book and much more at www.fortlauderdale.gov/benefits or on LauderShare at www.fortlauderdale.gov/laudershare. You may also contact the plan administrators directly to discuss your personal situation.

www.fortlauderdale.gov/benefits



www.fortlauderdale.gov/laudershare

CITY OF FORT LAUDERDALE HEALTH AND WELLNESS CENTER
(Operated by Marathon Health)

The City of Fort Lauderdale Health and Wellness Center (Center) provides employees and their families (children ages 6+) who are enrolled in one of the City's medical plans with high quality primary, preventive, and acute care at no cost for professional services. The City wants you and your family to be healthy. The City is investing in your health because, over the long term, it will help mitigate costs to both you and the City, and improve the quality of your life.

The Center's staff is licensed to diagnose, treat, and prescribe a wide variety of common illnesses and injuries. The staff will work with you to address your concerns about stress, diet, exercise, smoking, and other forces that impact your health and well-being. The experienced and knowledgeable staff includes:

- A Board-Certified Family Practice Physician
- A Board-Certified Physician Assistant
- A Board-Certified Nurse Practitioner
- A part-time Registered Dietician
- Medical Assistants

The City's Onsite Wellness Coordinator is also available at the Wellness Center. The role of the Coordinator is to educate employees and their covered dependents about Cigna benefits, resolve plan-related issues, and facilitate City wellness events. The Coordinator can be contacted at 954-652-1306. Cigna customer service representatives are available 24/7 and may be reached toll-free at 1-800-244-6224.

The Center follows the same rules and privacy regulations that protect your privacy at your personal physician's office, a hospital, or other health provider. In fact, the privacy of your personal health information is protected by the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules.

CENTER INFORMATION

City of Fort Lauderdale Health and Wellness Center
4750 North Federal Highway, Suite 300
Fort Lauderdale, FL 33308

Telephone: 754-206-2420
Fax: 1-954-867-5583 (must dial 1 in front)

Monday - Wednesday / Friday: 7am – 4 pm
Thursday: 7 am – 6 pm
Saturday: 8 am – Noon
Closed on Sundays and holidays
Closed Daily for lunch 1 pm - 2 pm

To schedule an appointment, call 754-206-2420 or visit the Marathon Health secure website at **my.marathon-health.com**.

SERVICES

The Center provides high quality care and wellness services for the entire family including, but not limited to, treatment for:

- Common Illness
- Chronic Conditions
- Women's Health & Men's Health
- Minor Injuries
- Suture Removal
- Allergy Shots
- Sports Physicals
- EKG
- Health Coaching
- Health Assessments
- Nutrition

A complete list of services offered at the Center is available online at **www.fortlauderdale.gov/benefits** or **www.fortlauderdale.gov/laudershare**.

LAB SERVICES

Many lab tests can be processed at the Center, including hemoglobin A1C, lipid panel, stools for occult blood, fasting glucose, random glucose, rapid strep, urinalysis, oxygen saturation levels, influenza A and B, mononucleosis tests, pregnancy tests, and more. All tests processed at the Center are at no charge to employees and family members enrolled in one of the City's medical plans. All other laboratory tests (i.e., urine culture, strep culture, complete blood count, chemistry profile, TSH) can be drawn by Marathon Health providers, but will be sent to an external laboratory for processing. The external laboratory will submit a claim to your medical plan for this service, and you may be responsible for a portion of the bill.

PRESCRIPTION MEDICINE PROVIDED AT TIME OF TREATMENT

The City's Health and Wellness Center stocks a supply of 30 to 40 prescription medications that the medical staff may dispense as part of your medical care. A list of the current medications provided at the is available online at **www.fortlauderdale.gov/benefits** or **www.fortlauderdale.gov/laudershare**. The Health and Wellness Center is not a pharmacy. Prescriptions written by another physician cannot be filled at the Health and Wellness Center, but in many cases, and in the context of care the staff provides, you and your family may be able to get certain medications at the Center at no cost.

WELLNESS INITIATIVES

The City's Health and Wellness Center is not just for when you are sick. The medical staff helps employees and their family members stay healthy, achieve health goals, and manage chronic conditions by working with individuals to create a personalized, step-by-step health plan. These plans empower people with chronic conditions to be more active and prevent medical conditions from becoming more serious in the future. Medical staff can also address concerns about stress, diet, exercise, smoking, and other forces that impact health and well-being.

Biometric Screening and Health Risk Assessment (HRA) Questionnaire: Employees, retirees, and covered spouses/domestic partners participating in one of the City's medical plans must complete a biometric screening for each plan year to avoid being charged a post-tax biometric surcharge per person, per paycheck. The post-tax biometric surcharge will continue until the requirements are completed. Newly eligible employees and their covered spouse/domestic partner (if applicable) have 30 days from their medical coverage effective date to complete the biometric screening and HRA questionnaire. It is recommended that Cigna medical plan enrollees complete a HRA questionnaire. Completing the HRA questionnaire is a requirement for eligible employees who wish to participate in the City's Motivate*Me*® Wellness Incentive Program.

The City's Health and Wellness Center or your personal physician may conduct the biometric screening and review the data on a personal and confidential basis directly with you to develop an action plan to improve your health.

Tobacco Use: This initiative only applies to employees and retirees participating in one of the City's medical plans. Newly eligible employees who are tobacco users have 60 days from their medical coverage effective date to complete a City authorized Tobacco Cessation Program (if applicable) to avoid paying a $25 biweekly post-tax surcharge. The City's authorized Tobacco Cessation Programs are:

- One-on-one or group programs through the City's Health and Wellness Center: Call 754-206-2420
- Online/phone program through Cigna: Register online at **www.mycigna.com** or call 866-417-7848
- IQuit program with Area Health Education Center (AHEC) at **www.ahectobacco.com/calendar**

Motivate*Me*® WELLNESS INCENTIVE PROGRAM (WIP)

The City of Fort Lauderdale is committed to your overall health and well-being. The Benefits Section of the Human Resources Department is excited to continue offering **Motivate*Me*®**, the City's voluntary **Wellness Incentive Program** to eligible employees.

The purpose of Motivate*Me*® is to **provide you with information about your current health status** and promote wellness-related activities to **encourage, engage, and help you take charge of and improve your health and happiness** while at work or at home. With Motivate*Me*®, you have the opportunity to earn a valuable incentives while improving your health.

Who can participate in the Motivate*Me*® WIP?

All permanent, full-time, active City employees enrolled in one of the City's medical plans can participate, including:

- International Association of Firefighters
- Teamsters Employee Group
- Confidential
- Management and Management Fellowship Program
- All Federation of Public Employees, including Federation employees not enrolled in one of the City's medical plans based on their Collective Bargaining Agreement.

What does Motivate*Me*® Offer?

The City will provide you with an annual **$500** (taxable) wellness incentive for the healthy actions you take through Cigna's Motivate*Me*® WIP. The goal is to motivate you to get your annual checkup, know your key health numbers and, ultimately, take control of your health.

How does Motivate*Me*® Work?

You must complete the three required goals and earn at least 200 additional points through wellness-related activities every calendar year between January 1 and December 31 to receive an annual $500 (taxable) wellness incentive. The incentive is payable after March 31 of the following year (to allow for reporting of claims data into your Motivate*Me*® Incentive Awards account).

TO EARN THE WELLNESS INCENTIVE:

1. You MUST complete all three of the following Required Program Goals:

- Annual Physical (Preventive Exam) – 100 Points
- Biometric Health Screening (blood pressure check, cholesterol screening, blood glucose/blood sugar screening, and height and weight measurements) – 100 Points
- Cigna's Personalized Health Assessment online at myCigna.com or the Marathon Health Questionnaire from the City's Employee Health and Wellness Center – 100 Points

2. Complete any of the following wellness activities to earn 200 additional points:^

Preventive Screenings or Health Coaching

- Flu Shot – 50 Points
- Annual OB/GYN Exam – 50 Points
- Mammogram* – 50 Points
- Colonoscopy* – 50 Points
- Cervical Cancer Screening – 50 Points
- Prostate Cancer Screening – 50 Points
- Health Coaching Session at the City's Health and Wellness Center – 50 Points

^ WIP Required Program Goals and Preventive Screening/ Coaching activity points will be credited one time per completion of an activity per payout year. Duplicate services will not be credited toward the annual incentive.

Self-Reported Activities (You must enter/report these activities in your myCigna.com account by December 31.)

- Complete a Wellness Activity (e.g., Lunch/Breakfast and Learns, Employee Assistance Program webinars, City walks, Tobacco and Stress Management Programs) – 25 points each (4 per year)
- Complete a Physical Activity (e.g., gym workouts, walking, exercise classes) – 25 points each (4 per year)
- Complete a Weight Management Activity (e.g., Weight Watchers, Jenny Craig, other weight management program) – 25 points each (4 per year)

WELLNESS INCENTIVE PROGRAM

City of FORT LAUDERDALE

All services performed at the City's Health and Wellness Center are available at no cost, except for those services previously listed with an asterisk (*). Services outside the Center are subject to your medical plan benefits.

All Biometric Screening and Health Assessment information will be confidentially collected and stored by the participant's health plan or Marathon Health and Wellness. The results are provided only to the participant; by law, they cannot be shared with an employer.

Services are available at no cost if the Affordable Care Act (ACA) guidelines are met and services are provided in-network.

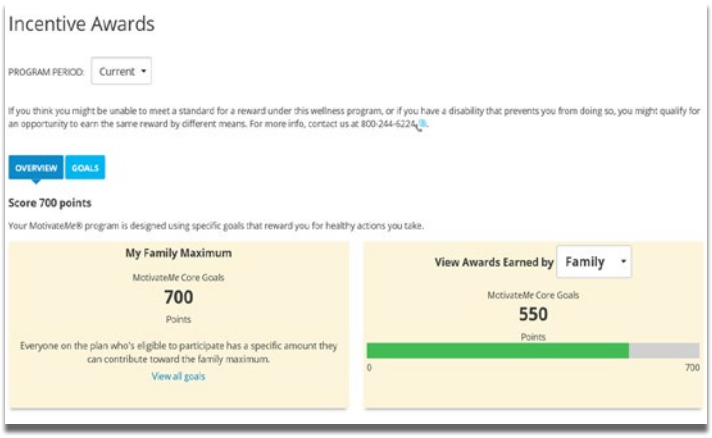
Wellness activities will be tracked online through your myCigna.com account in Incentive Awards, eliminating the need for paper forms. Except for self-reported activities and goals, wellness activity completion will be automatically reported.

Why participate in WIP?

If you complete the three required goals and earn at least 200 additional non-duplicated wellness activity points between January 1 and December 31, you will engage in beneficial wellness activities and you will also be rewarded with a $500 (taxable) wellness incentive.

How do I receive my WIP payout?

1. Record your self-reported wellness activities in your **myCigna.com** account in Incentive Awards.
2. Complete your wellness activities. Wellness activities that are automatically reported through Cigna claims will be visible in your Incentive Awards account by December 31.
3. You must be an active eligible City employee at the end of the calendar year (as of December 31).
4. After the conclusion of the calendar year, Cigna will provide a list of all employees who completed the three required goals and earned at least 200 non-duplicated additional points. The City will issue the $500 (taxable) WIP payout after March 31 of the following year to allow for reporting of claims data into your Cigna Motivate*Me*® Incentive Awards account.



All eligible employees must track and record their wellness activities through their MyCigna.com account. There are only two (2) exceptions that will require forms:

1. Eligible members of the Federation of Public Employees who are not enrolled in a City Medical Plan.
2. Eligible City employees who are enrolled in one of the City's medical plans as a dependent (spouse or domestic partner) of another City employee.

How can I participate and receive my incentive reward if I qualify as one of these two (2) exceptions?

1. Record your wellness activities on the Wellness Incentive Tracker Form (both Part 1 and Part 2) found on LauderShare at www.fortlauderdale.gov/laudershare or www.fortlauderdale.gov/benefits. This form must be completed with the three required goals and at least 200 non-duplicated additional points.
2. Submit the completed Wellness Incentive Tracker form AND the completed Wellness Incentive Program Physician Verification form(s) to the City's onsite Wellness Coordinator. BOTH forms must be completed and received by December 31 to receive your WIP payout. Please fax the completed forms to 860-847-5126 OR submit/mail to: City of Fort Lauderdale Health and Wellness Center, 4750 N. Federal Highway, Suite 300, Fort Lauderdale, FL 33308, Attention: Wellness Coordinator, Phone: 954-652-1306. Retain your proof of mailing or fax confirmation.
3. You must be an active eligible City employee at the end of the calendar year (as of December 31.
4. After the conclusion of the calendar year, Cigna will provide a list of all employees completed the three required goals and earned at least 200 non-duplicated additional points. The City will issue the $500 (taxable) WIP payout after March 31 of the following year.

Who do I contact for more information?

For more information, please contact Human Resources-Benefits Section at (954) 828-5160 or **Healthyliving@fortlauderdale.gov**. You may also contact the City's Onsite Wellness Coordinator at (954) 652-1306.

Motivate*Me*® is a voluntary wellness program available to all employees enrolled in the Cigna Medical Plan. The program is administered by Cigna according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program, you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood pressure check, cholesterol screening, a blood glucose/blood sugar screening, and a measurement of height and weight. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive a $500 (taxable) incentive for completing the three required goals and earning at least 200 non-duplicated additional points. In order to qualify for the incentive, you must complete the biometric screening, an annual physical (preventive exam), and health risk assessment for 300 points. An additional 200 wellness activity points are earned by employees who participate in certain health-related activities (i.e., getting a flu shot, Health Coaching at the City's Health and Wellness Center, attend a Lunch or Breakfast and Learn, complete physical or weight management activities) of their choice within the program guidelines. Although you are not required to complete the HRA or participate in the biometric screening and other wellness activities, only employees who do so will receive the $500 (taxable) incentive.

For all participants: If you think you might be unable to meet a standard for a reward under this wellness program you might qualify for an opportunity to earn the same reward by different means, contact the City of Fort Lauderdale's Wellness Coordinator at (954) 652-1306 or Human Resources, Benefits Section at (954) 828-5160.

For participants who may have an impairment: If you are unable to participate in any of the program events, activities, or goals, because of a disability, you may be entitled to a reasonable accommodation for participation, or an alternative standard for rewards. For worksite accommodations, please contact the City Benefits Office at 954-828-5160. For accommodations with online, phone, or other Cigna programs, contact the City of Fort Lauderdale's Wellness Coordinator at 954-652-1306, Human Resources, Benefits Section at 954-828-5160, or Cigna at 800-244-6224.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as in person, telephonic, or online coaching. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information
We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and The City of Fort Lauderdale may use aggregate information it collects to design a program based on identified health risks in the workplace, Cigna, Motivate*Me*®, and Marathon Health, a third party vendor who staffs and manages The Health and Wellness Center, will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) Cigna, Motivate*Me*® and Marathon Health, a third party vendor who staffs and manages The Health and Wellness Center (if authorized) in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you as soon as possible within the time frame specified by law.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the City of Fort Lauderdale's Wellness Coordinator at 954-652-1306 or Human Resources, Benefits Section at 954-828-5160.

OPEN ACCESS PLUS IN-NETWORK PLANS (OAPIN 1 (HMO1), OAPIN2 (HMO2))

With Cigna's Open Access Plus In-Network Plans, you get access to a large network of health care professionals and facilities. Each time you need care, you choose the in-network doctor or facility that works best for you.

Depending on your plan, you may have to pay an annual amount (deductible) before the plan begins to pay for covered medical costs. Once you meet your deductible, you pay a copay or coinsurance (a portion of the charges) for most services from an in-network doctor or facility. Then, the plan pays the rest. Once you reach an annual limit on your payments (out-of-pocket maximum), the medical plan pays your covered medical care costs at 100%.

In-network: In order for your medical care to be covered by the plan, you must choose a health care professional who is in the Cigna Open Access Plus network.

No-referral specialist care: If you need to see a specialist, you do not need a referral to see an in-network doctor.

Out-of-network: If you choose to see a doctor who is not in the network, you will not have coverage except in emergencies.

Emergency and urgent care: When you need care, you have coverage.

CONSUMER DRIVEN HEALTH PLAN (CDHP) - WITH HEALTH REIMBURSEMENT ACCOUNT (HRA)

The Cigna CDHP provides a medical plan with an HRA funded by the City to help pay for some of the costs of covered expenses, including medical expenses and prescription drugs.

How the HRA Works

- Per IRS Section 125, only tax qualified dependents are eligible to use HRA funds.
- At the start of the year, the City deposits a specific dollar amount in your HRA.
- Your account is used to pay 100% of eligible medical expenses until the money is used up.
- The medical costs that were paid from your HRA count toward your deductible (the amount you pay before your plan starts to pay), reducing your share.
- When you reach your deductible, you share the costs for covered medical expenses (coinsurance).
- You are protected by an annual limit on how much you pay.
- At the end of the year, any unused HRA funds will roll over to the following year.
- If you switch medical plans or leave the City, you forfeit your unused HRA funds.

CONSUMER DRIVEN HEALTH PLAN (CDHP) - WITHOUT HEALTH REIMBURSEMENT ACCOUNT (HRA)

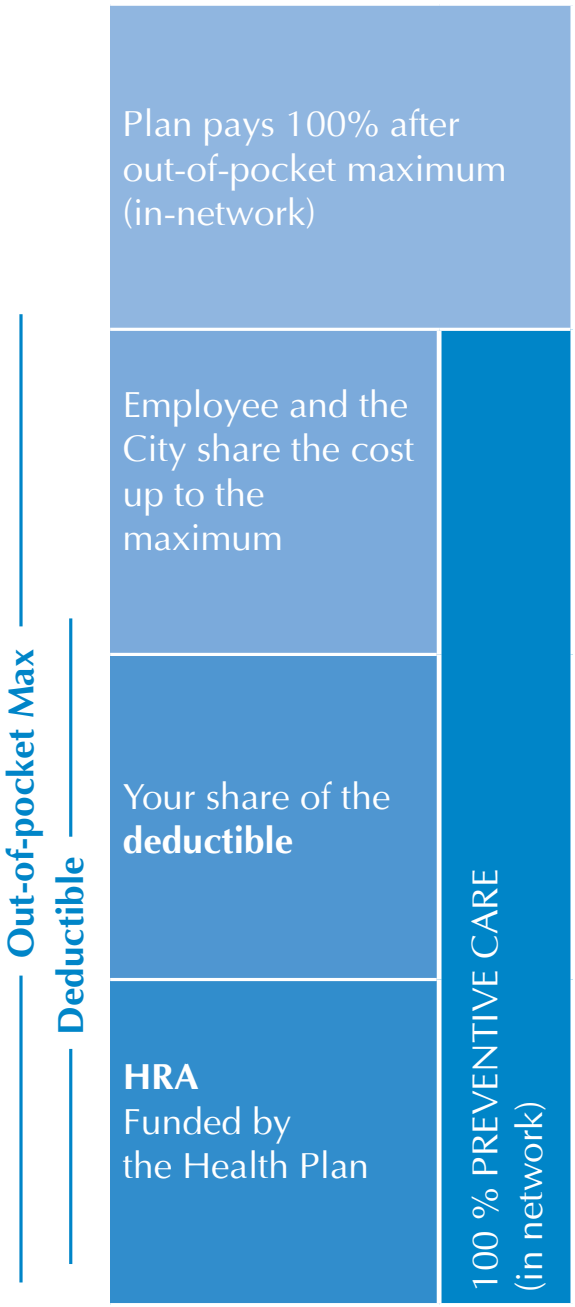
- Per IRS Section 125, non-tax qualified dependents (i.e. adult child dependents (ages 26-30), domestic partners and domestic partner's child(ren)) are not eligible to use HRA funds.
- Non-tax qualified dependents will be enrolled in their own medical plan that is separate from the employee and tax qualified dependents.
- Non-tax qualified dependents will share their own deductible and out-of-pocket maximum that is separate from the employee and tax qualified dependents.
- When non-tax qualified dependents reach their deductible, they share the costs for covered medical expenses with the City (coinsurance).
- Non-tax qualified dependents are protected by an annual limit on how much they pay.

2020 MEDICAL PLAN COMPARISON SUMMARY

Medical Plan Coverage	OAPIN1 (HMO1)	OAPIN2 (HMO2)	Consumer Driven Health Plan (CDHP)	
Health Reimbursement Account (HRA) * (For Employees and their Tax Qualified Dependents ONLY)	n/a	n/a	$750-EE, $1,000-EE+1, $1,500=EE + 2 or more	
Medical Plan Coverage	**OAPIN1 (HMO1) You Pay**	**OAPIN2 (HMO2) You Pay**	**Consumer Driven Health Plan (CDHP) You Pay**	
			In-Network	Out-of-Network**
Deductible	No Deductible	$1,000=EE $2,000=EE+1 $3,000=EE+Family	$2,000=EE $3,000=EE+1 $4,000=EE+2 or more	$2,000=EE $3,000=EE+1 $4,000=EE+2 or more
Coinsurance	See Below	See Below	You pay 10%	You pay 30%
Your Out-of-Pocket Maximum	$5,000=EE; $7,000=EE+1 $10,000=EE+2 or more	$6,350=EE $10,000=EE+1 $12,700=EE+2 or more	$5,000=EE, $7,000=EE+1, $10,000=EE+2 or more (Includes calendar year deductible & coinsurance)	$5,000=EE, $7,000=EE+1, $10,000=EE+2 or more (Includes calendar year deductible & coinsurance)
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Preventative Services	No Charge	No Charge	No Charge	See Below***
Primary Care Physician and Telehealth	$40	$40	Subject to calendar year deductible & coinsurance (HRA applies)	Subject to calendar year deductible & coinsurance (HRA applies)
Specialist Physician	$60	$60		
Maternity	$60 Initial Visit****	$60 Initial Visit****		
Hospital	$500/day, $2,500 Maximum	Deductible then 20% Coinsurance		
Outpatient Surgery	$500	Deductible then 20% Coinsurance		
Outpatient Diagnostics (X-rays, Ultrasound, etc.)	10% Coinsurance	10% Coinsurance		
Outpatient Diagnostics (CAT & PET scans, MRI)	$200 per test	$200 per test		
Routine Lab	10% Coinsurance	10% Coinsurance		
Emergency Room	$200	$200		
Urgent Care	$60	$60		
Mental Health (outpatient)	$40	$40		
Mental Health (inpatient)	$500 per day for first 5 days	Deductible then 20% Coinsurance		
Allergy Treatments/Injections	$10	$10		
Ambulance	no charge	$100 copay		
Prescription Drugs Pharmacy, 30-day supply ***	$20 generic $40 preferred $60 non-preferred	$20 generic $40 preferred $60 non-preferred	Subject to calendar year deductible & coinsurance of 30% generic, 40% preferred, 60% non-preferred (HRA applies)	Not Covered
Prescription Maintenance Drugs Retail or Mail Order, *** Mandatory 90-day supply ****	$40 generic $80 preferred $120 non-preferred	$40 generic $80 preferred $120 non-preferred		
Prescription for Chronic Conditions & Preventative ****	Generic prescription provided - waiving copays	Generic prescription provided - waiving copays	Generic prescription provided - waiving copays	Not Covered
Vision	(only medical conditions)	(only medical conditions)	(only medical conditions)	(only medical conditions)

* Health Reimbursement Account (HRA) City annual contributions: The HRA funding is prorated for enrollment after January and only accessible to tax qualified dependents.. ** Cigna's reimbursement is based on Usual Customary and Reasonable (UCR) charges. ***30% coinsurance after deductible, waived for children up to 16 years of age. ****See the applicable plan document for details regarding benefit payments. *****Members Pay the Difference generic program pharmacy benefit rules apply. ****** Cigna 90 Now Program: For specified maintenance medications, you must obtain a 90-day prescription (filled at either a 90-day network retail pharmacy or Cigna Home Delivery) for the medication to be covered by the plan. Otherwise, after three 30-day fill(s), you pay the entire cost of the prescription.

CONSUMER DRIVEN HEALTH PLAN (CDHP) EXAMPLE - WITH HEALTH REIMBURSEMENT ACCOUNT (HRA)



Maximum Out-of-Pocket: This is the limit you will pay on an annual basis (each calendar year) for covered expenses regardless of how high your medical bills get. Participants have an out-of-pocket maximum for their eligible in-network medical expenses depending on their tier of coverage. You may be billed for charges in excess of CIGNA's usual customary and reasonable charges if you use out-of-network providers.

Employee = $5,000
Employee + 1 = $7,000
Family = $10,000

Coinsurance: This is the percentage of costs you pay for covered health care services after you have paid your deductible. **The plan pays the rest.**

Employee pays 10% in-network or 30% out-of-network
City pays 90% in-network or 70% out-of-network

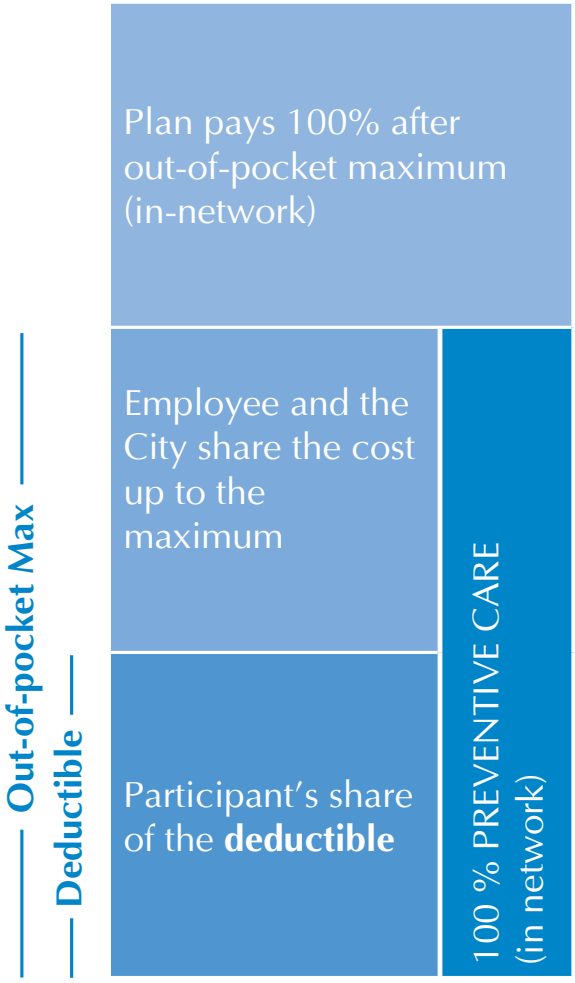
Deductible: A deductible is the portion of your covered medical expenses you are responsible for paying during each plan year until you reach the specified amount. Then, your plan will begin to pay a portion of covered medical costs (coinsurance). After the money in the HRA is spent you pay for covered medical expenses until you reach your individual annual deductible.

Employee = $2,000 ($1,250 after $750 HRA)
Employee + 1 = $3,000 ($2,000 after $1,000 HRA)
Family = $4,000 ($2,500 after $1,500 HRA)

Health Reimbursement Account (HRA): At the start of the year, the City deposits a specific contribution in your HRA. Your account automatically pays eligible medical expenses until the money is used up. The medical costs that were paid from your HRA count toward your deductible, reducing your share. At the end of the year, any unused HRA funds will roll over to the following year. If you switch medical plans or leave the City, you forfeit your unused HRA funds. The HRA fund can only be used for covered medical and prescription drug expenses.

2020 City Annual HRA Contributions:
Employee = $750
Employee + 1 = $1,000
Family = $1,500
Note: HRA funding is prorated for enrollment after January.

CONSUMER DRIVEN HEALTH PLAN (CDHP) EXAMPLE - WITHOUT HEALTH REIMBURSEMENT ACCOUNT (HRA)



Maximum Out-of-Pocket: This is the limit the participant will pay on an annual basis (each calendar year) for covered expenses regardless of how high their medical bills get. Participants have an out-of-pocket maximum for their eligible in-network medical expenses depending on their tier of coverage. Participants may be billed for charges in excess of CIGNA's usual customary and reasonable charges if they use out-of-network providers.

Non-tax Qualified Adult Child Dependent and/or Domestic Partner = $5,000

Non-tax Qualified Domestic Partner + 1 Child of Domestic Partner = $7,000

Non-tax Qualified Domestic Partner + 2 or more Children of Domestic Partner = $10,000

Coinsurance: This is the percentage of costs you pay for covered health care services after you have paid your deductible. **The plan pays the rest.**

Participant pays 10% in-network or 30% out-of-network

City pays 90% in-network or 70% out-of-network

Deductible: A deductible is the portion of your covered medical expenses you are responsible for paying during each plan year until you reach the specified amount. Then, the plan will begin to pay a portion of covered medical costs (coinsurance).

Non-tax Qualified Adult Dependent and Domestic Partner = $2,000

Non-tax Qualified Domestic Partner + 1 Child of Domestic Partner = $3,000

Non-tax Qualified Domestic Partner + 2 or more Children of Domestic Partner = $4,000

HRA EXAMPLES

Meet the Smiths: A family of five

The Smiths are an active family of five. All family members get their yearly wellness exams. Mrs. Smith has high cholesterol that requires her to take prescription medication daily. She also suffers from severe low back pain and sees her chiropractor regularly. The Smiths are enrolled in family coverage with $1,500 in their HRA.

Service (In-Network)	Discounted Provider Charge	The Smith's HRA Account $1,500	The Smith's Responsibility
5 Annual preventive exams	Plan pays direct	$0	$0
6 Chiropractic visits	$510	-$510	$0
2 Urgent care visits	$260	-$260	$0
2 Primary doctor visits	$124	-$124	$0
Cholesterol prescription	$252	-$252	$0
Year-end balance	$1,146	$354	$0

Meet the Davidsons: Married couple, late 50s

Mr. Davidson was in a severe auto accident. As a result, he was hospitalized and his recovery consisted of rehabilitation and many visits to specialists. The Davidsons are enrolled in the Employee + 1 with $1,000 in their HRA account.

Service (In-Network)	Discounted Provider Charge	The Davidson's HRA Account	The Davidson's Responsibility
2 Annual preventive exams	Plan pays direct	$0	$0
Hospitalization	$25,000	-$1,000	-$2,000 remaining deductible -$2,200 (10% coinsurance on $22,000 hospital)
2 Radiology visits	$2,500	$0	-$4,200 -$250 (10% coinsurance)
20 Rehabilitation visits	$2,500	$0	-$250 (10% coinsurance)
Year-end balance	$32,500	$0	-$4,950

2020 PHARMACY BENEFIT PROGRAM FOR ALL CIGNA MEDICAL PLANS

Cigna continually reviews medicines, products, and prices for the City of Fort Lauderdale. This review includes evaluating costly medications that have clinically effective lower-cost alternatives, which may help you and the City obtain cost savings. Prescription drugs are not covered out-of-network.

Cigna Value 3-Tier Prescription Drug List (PDL)

- Tier 1: Generic, Tier 2: Preferred Brands, Tier 3: Non-Preferred Brands
- A formulary is a comprehensive list of preferred drugs chosen on the basis of quality and efficacy by an independent committee of physicians and pharmacists.
- Cigna's Value 3-Tier Drug List of covered drugs is available for review at www.fortlauderdale.gov/benefits. If you have any questions or need additional information, please call Cigna at 1-800-244-6224.

Mandatory 90-day Supply Required for Maintenance Medications - Cigna 90 Now Maintenance Medication Program

- Maintenance medications are taken regularly, over time, to treat an ongoing health condition, such as diabetes, high blood pressure, cholesterol or asthma.
- Filling your prescriptions in a 90-day supply may help you stay healthy because having a larger supply of your medication on-hand typically means you're less likely to miss a dose. It also means you can make fewer visits to the pharmacy to refill your medication, and when filling a maintenance medication for a 90-day supply, OAPIN1 and OAPIN2 plan enrollees can save money by only paying for a 60-day supply. CDHP plan enrollees are subject to their plan deductible.
- For specified maintenance medications, you must obtain a 90-day prescription (filled at either a 90-day network retail pharmacy or Cigna Home Delivery) for the medication to be covered by the plan. Otherwise, after three 30-day fill(s), you pay the entire cost of the prescription. Cigna will not cover any of the cost.
- Maintenance medication 90-day local pharmacies include such pharmacies as CVS (Target), Walmart, and Navarro. Check MyCigna.com for a complete list of participating pharmacies.

Member Pay the Difference generic program

- In Florida, pharmacists automatically substitute generics for brand-name prescriptions unless a doctor specifies a brand is necessary. However, some members and practitioners continue to request brand-name prescriptions even though a generic equivalent is available. This can increase costs for both employers and members.
- With the Member Pay the Difference generic program, members can still receive the brand medication, but members will pay the brand-name copay plus the difference in cost between the brand-name medication and the generic, up to the brand name total cost. This additional cost for a brand-name drug when a generic equivalent is available is applicable even if a physician specifically prescribes a brand-name medication that has a generic equivalent. Physicians may appeal this decision to Cigna if there is medical evidence that supports why the member cannot take the specific generic medication.

For details and specific information, please go to www.cigna.com.

MEMBER PAY THE DIFFERENCE GENERIC PROGRAM EXAMPLE FOR OAPIN1 AND OAPIN2 PLANS:

Here's an example:
Susan is deciding between a $100 brand-name medication and its $30 generic equivalent. According to her plan, she has a copay of:

- $20 for a 30-day supply of generic medications
- $40 for a 30-day supply of brand name medications

Generic	**If she chooses the generic, all she pays is her generic copay**	**$20**
Brand Name	**If she chooses the brand name, she pays** **$40** brand-name copay + **$70** brand-name costs ($100) – generic cost ($30) = **$110 TOTAL brand-name cost**	**$110**

USEFUL CIGNA TOOLS

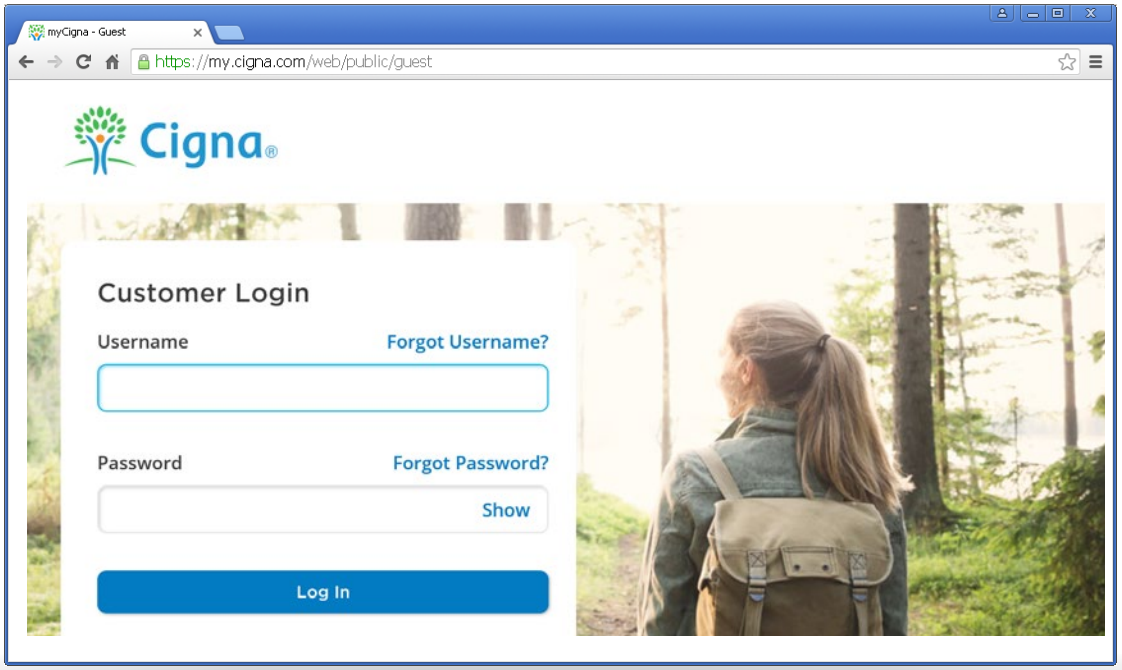
How to register on myCigna.com or myCigna mobile app

Register today. It is this easy:

- Go to myCigna.com and select "Register Now."
- Enter the requested information (i.e., name, address, and date of birth).
- Confirm your identity with secure information, such as your Cigna ID, social security number, or complete a security questionnaire. This will make sure only you can access your information.
- Create a user ID and password.
- Review your information and submit.

Once registered, you will be able to find all your coverage information online.
My Cigna.com provides you with the following tools:

- Access your Motivate*Me*® Wellness Incentive Program Account
- View your ID card information, which can also be faxed or emailed through the mobile app
- Find in network doctors, dentists, hospitals, pharmacies and medical services
- Manage and track claims
- See cost estimates for common medical and dental procedures and compare prescription costs
- Compare quality of care ratings for doctors and hospitals
- Access a variety of health and wellness tools and resources
- Review your coverages
- Fill your prescriptions and view your order history online through Cigna Home Delivery Pharmacy
- Track your account balances and deductibles
- Access Employee Assistance Program (EAP) benefits



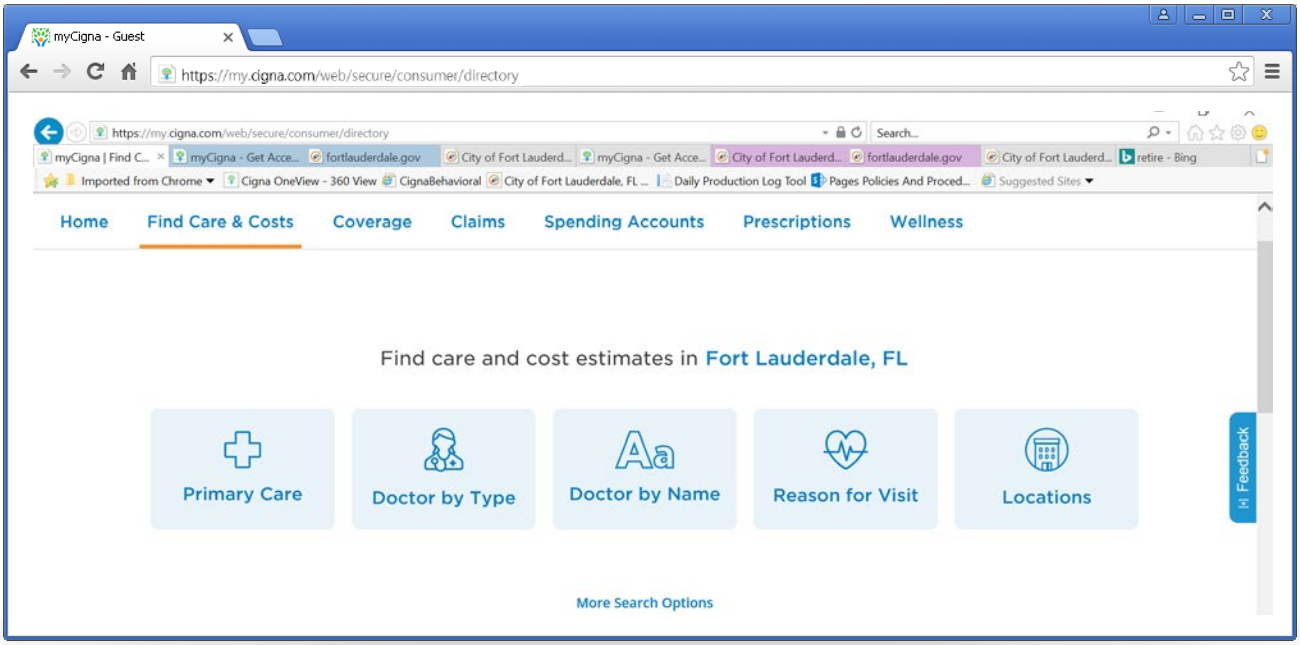
FIND A CIGNA DOCTOR OR FACILITY:

One Cigna network of providers for everyone: OpenAccessPlus

- OpenAccessPlus is the Cigna Network used for all three plans: OAPIN1 (HMO1), OAPIN2 (HMO2) and Consumer Driven Health Plan (CDHP).
- To search for a participating provider in the Cigna network, select "Find a Doctor or Facility" by logging into www.myCIGNA.com or by calling 1-800-244-6224. When choosing a physician, we encourage you to choose a Cigna Care Designated (CCD) Physician. Cigna Care Designated includes doctors who meet specific criteria in the areas of quality, number of patients treated, efficiency, and customer access. Cigna Care Designated Physicians are easily located on mycigna.com by a blue "C" and the title "Cigna Care Designation."

Cigna's Cost Estimator Tool

- The more you know about the cost and quality of doctors and hospitals, the easier it is to make the best choices for you and your family. After all, no one wants to pay too much for health care.
- The myCigna health care professional directory allows you to see integrated cost and quality information throughout the directory, helping you compare doctors and control health care spending.
- To help you make the most confident, cost-effective decisions about your care it is wise to compare costs and to understand how much your plan will pay and how much you will need to cover.



ONE GUIDE - Start using Cigna One Guide today – by app, chat, or phone.

App › Chat › Phone

Download the myCigna app or call 1-800-244-6224 to talk with your personal guide.

Cigna One Guide service can help you make smarter, informed choices and get the most from your plan. It's Cigna's highest level of support that provides enhanced live customer service and includes the use of a powerful app. One Guide personal support, tools, and reminders can help you stay healthy and save money. Your Cigna One Guide representative will be there to guide you through the complexities of the health care system and help you avoid costly missteps. The goal is a simpler health care journey for you and your family.

Call a Cigna One Guide representative to get personalized, useful guidance. Your personal guide will help you:

Understand your plan

- Know your coverage and how it works with your medical, prescription drug, and dental benefits.
- Get answers to all your health care or plan questions.

Get care

- Find the right in-network doctor, dentist, hospital, lab, pharmacy, or urgent or convenience care center to help you avoid unnecessary costs.
- Get dedicated one-on-one support for complex health situations.
- Connect to health coaches, pharmacists, and other resources.
- Stay on track with appointments and preventive care.

Save and earn

- Maximize your benefits and earn incentives for the Motivate*Me*® Wellness Incentive Program.
- Get cost estimates and service comparisons.

Personalized Customer Service

- Understand your Explanation of Benefits and claims.
- Proactive messaging based on individual health needs.
- Get help/personal assistance to resolve health care issues.
- Save time and money.
- Get answers to any other questions you may have about the plans or provider networks available to you.

CIGNA TELEHEALTH CONNECTION

Telehealth is the delivery of health-related services and information via telecommunications technologies, including telephones, smartphones, and personal computers, for virtual consultations. Among the most significant benefits are ease of access, convenience, time savings, and competitive cost.

What is Cigna Telehealth Connection?

Cigna Telehealth Connection is Cigna's voluntary telemedicine program (provided by Amwell and MDLIVE) that includes live appointments with board-certified doctors and pediatricians via video or phone who can diagnose and prescribe, when appropriate. Participants can choose the time and day that works best for them, with medical telehealth services available 24/7/365.

Does telehealth replace my primary care provider?

No. Telehealth is not intended to replace the City's Health & Wellness Center nor your primary care provider (PCP). For common or chronic conditions, a virtual consultation can sometimes be a convenient and affordable alternative to a provider's office or non-urgent emergency room (ER) visit. Communication with your PCP is important for continuity of care.

Can telehealth handle emergency situations?

No. Telehealth is designed to handle minor, non-emergency medical issues. You should NOT use telehealth if you are experiencing a medical emergency. If you have a medical emergency, you should dial 911 immediately or visit the nearest hospital.

USING TELEHEALTH

When should I consider using telehealth?

- When the City's Health and Wellness Center or your PCP is not available
- If you're considering an ER or an urgent care center for a non-emergency medical issue
- When traveling within the USA and in need of medical care (telehealth is not available outside of the USA)
- After normal business hours, nights, weekends, and even holidays

HOW IT WORKS

Who can use telehealth services?

Employees and covered dependents enrolled in one of the City's Cigna medical plans are eligible to use the program.

How do I access telehealth?

Employees enrolled in one of the Cigna medical plans and covered dependents may access telehealth services from either Amwell or MDLIVE.

A. **Through the web at myCigna.com**
   - Log in to myCigna.com
   - Select the Cigna Telehealth Connection
   - Select either Amwell or MDLIVE

B. **Download the MyCigna® App to access both telehealth providers through your smartphone or mobile device**

C. **By telephone**

Amwell: AmwellforCigna.com Phone: 1-855-667-9722
MDLIVE: MDLIVEforCigna.comPhone: 1-888-726-3171

COSTS AND PAYMENT

Are covered claims for visits with Amwell and MDLIVE telehealth doctors covered at my in-network rate?

Yes. The claims will be processed by Cigna and you will receive an explanation of benefits (EOB), just as you do when other medical claims are processed.

How much will it cost to use the programs?

The cost of the visit depends on your medical plan. The OAPIN1 and OAPIN2 medical plans will have a $40 primary care physician copayment and the CDHP will be the Cigna contracted rate subject to calendar year deductible and coinsurance (HRA applies).

Can I pay for my telehealth visit with a health reimbursement account (HRA) or flexible spending account (FSA)?

Yes. Telehealth is a qualifying expense for HRA or FSA accounts.

Will all registrations require a debit or credit card to be on file to cover the cost of the copay/coinsurance?

Yes. The payment information is gathered at point of consultation and kept on file; however, you may need to provide your credit card information for future consultations.

How do I pay for a prescription called in by a telehealth doctor?

Telehealth works the same as a primary care physician for prescribing medications. When you go to your pharmacy of choice to pick up the prescription, you will be responsible for any amount due based on your plan's coverage terms, including deductible, coinsurance, or copay requirements.

If the doctor recommends that I see a specialist or my PCP, do I still pay for the visit?

Yes. Like seeing any doctor, if you are referred to another doctor, the consultation fees still apply.

Am I charged if I miss a scheduled visit?

Appointments need to be canceled at least 12 hours before the time of your scheduled consultation to avoid being charged.

How can I get additional help if I have more questions about Amwell or MDLIVE?

You may call Amwell at 855-667-9722 or visit AmwellforCigna.com.
You may call MDLIVE at 888-726-3171 or visit MDLIVEforCigna.com.
You may also call the Cigna customer service number on the back of your Cigna ID card.

USE CIGNA TELEHEALTH CONNECTION TO CONNECT WITH A DOCTOR ABOUT:

General health

- Acne
- Allergies
- Asthma
- Bronchitis
- Colds and flu
- Diarrhea
- Earaches
- Fever
- Headaches
- Infections
- Insect bites
- Joint aches
- Nausea
- Pink eye
- Rashes
- Respiratory infections
- Shingles
- Sinus infections
- Skin infections
- Sore throats
- Urinary tract infections

Pediatric care

- Colds and flu
- Constipation
- Earaches
- Nausea
- Pink eye

For benefit-eligible employees other than International Association of Fire Fighters (IAFF)

The City offers two Cigna dental plan choices – DHMO and DPPO. Please go to www.cigna.com to view a list of participating dental providers. For DHMO providers, select Cigna Dental Care Access. For DPPO providers, select Cigna DPPO. Cigna will mail dental cards to plan participants.

1. The Cigna Dental Care Access DHMO plan focuses on maintaining oral health, prevention, and cost containment. Members must receive services from the participating primary care dentist (PCD) that they are assigned to for eligible services to be covered. Cigna will automatically assign a default dentist based on your home ZIP code. You can select or request to change your dentist at any time by contacting Cigna directly at 1-800-244-6224. Cigna will process your request as soon as administratively feasible. You may see your assigned dentist as often as necessary. There are no deductibles to meet and no waiting periods. Copayments for listed procedures are applicable at either a participating general dentist or participating specialist.

   A PCD may decide that a member needs to see a contracted dental specialist. No referral is necessary to see a network specialist.

   Specialists services: Should members need a specialist (i.e., endodontist, oral surgeon, periodontist, or pediatric dentist), they may be referred by a participating general dentist, or members can self-refer to any participating specialist. For DHMO plans, copayment amounts are applicable when treatment is performed by participating specialists.

2. The Cigna Dental PPO plan features a schedule of benefits for Preventive (100%), Basic (100%), Major (60%), and Orthodontic services all subject to exclusions and limitations.

Below is a very brief summary of the dental plan offered by the City of Fort Lauderdale. For further information, please refer to the Cigna plan documents at **www.fortlauderdale.gov/benefits**, LauderShare, or contact Cigna directly at 1-800-244-6224.

PLAN FEATURES	Participant Maximum	Preventive Services Exam, cleaning, fluoride, x-rays, sealants	Basic Services Fillings, periodontics, endodontics	Major Services Crowns, bridges, dentures	Orthodontia Up to 24 month treatment, children or adult braces
DENTAL HMO*	No Maximum	$0 copayments	Refer to Plan	Refer to Plan Copayments	Refer to Plan Copayments
	IMPORTANT: DHMO PARTICIPANTS MUST SELECT A PRIMARY CARE DENTIST • Go to **www.cigna.com**				
DENTAL PPO*	$1,500 Maximum annual benefit per person combined in or out of network	100% (no deductibles)	100% (no deductibles)**	60% (no deductibles)**	60% (no deductibles) $2,500 lifetime maximum

Cigna DPPO Plan offered to IAFF members only:

Visit www.cigna.com for a list of participating dentists. Non-participating dentists may bill you for charges above the amount covered by your Cigna Dental Plan.

Cigna will mail dental cards to plan participants.

PLAN FEATURES	Participant Maximum	Preventive Services Exam, cleaning, fluoride, x-rays, sealants	Basic Services Fillings, periodontics, endodontics	Major Services Crowns, bridges, dentures	Orthodontia Up to 24 month treatment, children or adult braces
DENTAL PPO*	$1,500 Maximum annual benefit per person combined in or out of network	100% (no deductibles)	80% (after $100 deductible)	50% (after $100 deductible)	50% (no deductible) $1,500 lifetime maximum

* Teeth missing prior to coverage under the Cigna Dental plans are not covered.
** Please see the applicable summary plan description on the City benefits website or Laudershare for all limitations and exclusions.** Please note if a non-network PPO dentist is used, there will be a $100 individual/$300 family deductible and 60% coverage for Basic and Major Services. Non-participating dentists may bill you for charges above the amount covered by your Cigna Dental Plan. Visit **www.cigna.com** to check out participating dentists.

VOLUNTARY VISION PLAN (EYE EXAMS, EYEGLASSES AND CONTACTS)

The Vision Plan is a voluntary stand-alone benefit and is provided by UnitedHealthcare for all eligible employees and their dependents. UnitedHealthcare also offers a network of national and independent vision providers and even provides substantial savings on hearing aids.

In-Network Benefits Summary

(Visit www.fortlauderdale.gov/departments/human-resources/employee-benefits/vision-benefits for more details)

1. Once every calendar year employees can get a comprehensive exam, spectacle lenses, and contact lenses instead of eye glasses. Once every other calendar year employees can get frames.
2. $130 retail frame allowance for private practice or retail chain providers
3. Standard scratch-resistant coating is available to all participants at no charge. Polycarbonate lenses are covered in full for dependent children up to age 19. Other optional lens upgrades may be offered at a discount (discount varies by provider).
4. Coverage for a second eye exam each plan year for members up to age 13 at no additional premium cost; standard copays apply.
5. Coverage for a new pair of glasses (frames and lenses) for a covered child up to age 13 at no additional premium cost if the vision prescription changes .5 diopter (a unit to measure the optical power of the lens an eye requires) or greater in a plan year. Standard copays apply.

Contact lens benefit:

- Selection contact lenses refers to UnitedHealthcare's formulary contact list. A copy of the list can be found at www.myuhcvision.com. The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full (after copay). If you choose disposable contacts, up to four boxes are included when obtained from an in-network provider. $25 copay for in-network and reimbursed for up to $105 if out-of-network.
- Non-selection contact lenses are contact lenses not listed on the formulary. A copy of the list can be found at myuhcvision.com. A $105 allowance is applied toward the purchase of contact lenses outside the covered selection (materials copay does not apply).
- Medically necessary contact lenses instead of eyeglasses: $25 copay (then covered in full) for in-network and reimbursed up to $210 if out-of-network.

	In-Network copays	Out-of-network Reimbursements (copays do not apply)
Exam	$10	$40
Frames and one of the following:	$25	$45
Single vision lenses		$40
Bifocal lenses		$60
Trifocal lenses		$80
Lenticular lenses		$80
Selection contact lenses		$105
* Non-selection contact lenses in lieu of eye glasses	$105 allowance	$105
Medically necessary contact lenses in lieu of eye glasses	$25 (then covered in full)	$210

CITY PAID GROUP TERM LIFE INSURANCE

The City provides all active full-time, senior management fellows, and temporary full-time employees with group term life insurance at no cost equivalent to one times their base salary up to a maximum of $300,000. This coverage includes Accidental Death and Dismemberment (AD&D). The amount of coverage will be updated to reflect the employee's base salary as of January 1 of each year.

Life insurance is a tax-free benefit in amounts up to **$50,000**. The Internal Revenue Service (IRS) requires you to pay income tax on the value of any amount exceeding **$50,000**. The IRS-determined value is called "imputed income" and is calculated from the government's "Uniform Premium Table I." Coverage provided each calendar year will be based on the employee's age as of the last day of the tax year.

UNIFORM PREMIUM TABLE I

AGE	COST (per $1,000 for 1 month)
Under age 25	.05
25 to 29	.06
30 to 34	.08
35 to 39	.09
40 to 44	.10
45 to 49	.15
50 to 54	.23
55 to 59	.43
60 to 64	.66
65 to 69	1.27
70 and Older	2.06

Example of how life insurance imputed income is calculated:

- **$81,000** Annual salary for 46-year-old City Community Builders (as of December 31, 2019)
- **$81,000** minus **$50,000** IRS non-taxable salary limitation = **$31,000**
- **$31,000** annual salary over IRS limitation / $1,000 x .15 IRS tax rate from table above = **$4.65 monthly imputed income**
- **$4.65** monthly imputed income **x .28** estimated tax rate = **$1.30** estimated tax per month
- **Annual imputed income** = **$55.80 x .28** estimated tax rate = **$15.60** estimated tax per year

81,000.00	Insurance amount
-50,000.00	IRS non-taxable salary limitation
31,000.00	Annual salary over IRS limitation
/ 1,000	Cost per $1,000 salary for one month per table above
31	
X 0.15	IRS tax rate from table above
4.65	Monthly imputed income
X 0.28	Estimated tax bracket rate
1.30	Estimated tax per month
55.80	Annual imputed income
X 0.28	Estimated tax bracket rate
15.60	Estimated annual tax

VOLUNTARY GROUP TERM LIFE INSURANCE

Newly eligible employees (e.g., new hires) may purchase additional life insurance coverage without completing a Medical History Statement (also known as Evidence of Insurability (EOI)), of up to $300,000 at the rates indicated below (for their age bracket). Eligible employees may apply for life insurance coverage in increments of $5,000 within a range of $10,000 (minimum) to $400,000 (maximum). Employees must be actively at work for coverage to become effective. The voluntary group term life insurance includes Accidental Death and Dismemberment (AD&D) for both employees and spouses/domestic partners. Please refer to Standard Insurance Company's certificates of coverage for complete information about your benefits.

Employees who have a qualifying life event (QLE) may apply for new or additional coverage, but will be subject to EOI and must complete a Medical History Statement regardless of the amount (unless newly eligible). The completed Medical History Statement may be downloaded from the Benefits web page at www.fortlauderdale.gov/benefits and must be submitted or faxed directly to Standard Insurance Company or may be submitted via the online process at www.standard.com/mybenefits/mhs_ho.html. using Group ID #754544.

All eligible employees should complete a life insurance beneficiary designation form that may be obtained on the Benefits web page. To complete the beneficiary designation, the date of birth for each beneficiary listed will be required. Please submit the completed form to the Benefits Section, HR.

You may elect to take this coverage with you when you terminate your City employment.

BI-WEEKLY VOLUNTARY TERM LIFE RATES

Voluntary Standard Insurance Company group term life insurance automatically includes AD&D. If you die from natural causes your beneficiary receives the term amount. If you die as a result of an accident your beneficiary will receive term amount plus AD&D (equal to term amount).

Newly eligible employees may secure up to $300,000 guaranteed issue voluntary group term life insurance and up to $400,000 with EOI. **Life Insurance coverage reduces to 65% of coverage beginning at age 70. The premium will be adjusted to reflect the reduced coverage.**

HOW MUCH YOUR COVERAGE COSTS

Because this insurance is offered through the City of Fort Lauderdale, you'll have access to competitive group rates, which may be more affordable than those available through individual insurance. You'll also have the convenience of having your premium deducted directly from your paycheck. How much your premium costs depends on a number of factors, such as your age and the benefit amount.

If you buy coverage for your spouse, your monthly rate is shown in the table below. Use the same formula to calculate the premium that you used for yourself, but use your age and your spouse's rate.

If you buy Life coverage for your child(ren), your monthly rate is $0.50 for $10,000, no matter how many children you're covering.

HOW MUCH YOUR COVERAGE COSTS (continued)
Use this formula to calculate your premium payment:

_____ ÷ 1000 = _____ x _____ = _____ ➡ _____

Enter the amount of coverage you are requesting between $10,000 - $400,000.

Enter your rate from the rate table.

This amount is an estimate of how much you would pay each month.

To get a sense of your biweekly premium, multiply your monthly premium amount by 12 and then divide by 26.

Age (as of January 1)	Your Rate* (Per $1,000 of Total Coverage)	Your Spouse's Rate** (Per $1,000 of Total Coverage)
<30	$0.063	$0.063
30–34	$0.072	$0.072
35–39	$0.072	$0.072
40–44	$0.097	$0.097
45–49	$0.158	$0.158
50–54	$0.235	$0.235
55–59	$0.373	$0.373
60–64	$0.416	$0.416
65–69	$0.751	$0.751
70–74	$1.224	$1.224
75+	$2.080	$2.080

*Includes a monthly AD&D rate of $0.02 per $1,000 of AD&D benefit.
**Includes a monthly AD&D rate of $0.02 per $1,000 of AD&D benefit for your spouse.

SPOUSE/DOMESTIC PARTNER COVERAGE: Spouse/domestic partner coverage is available in increments of $500 as long as the employee is enrolled in voluntary group term life insurance. Amounts more than $50,000 are subject to EOI. Spouse/domestic partner coverage cannot exceed half of the employee's coverage. Spouse/domestic partner rates are based on the employee's age. If you elect coverage for your spouse, your monthly rate is shown in the table above. Use the same formula to calculate the premium that you used for yourself, but use your age and your spouse's rate. Employees adding a spouse/domestic partner outside of their initial eligibility period must provide EOI. The employee must be enrolled in voluntary group term life insurance to select spouse/domestic partner coverage.

CHILDREN COVERAGES: Children may be enrolled for $10,000 of coverage through the end of the calendar year they turn age 26 for a biweekly rate of $0.23 (covers all children at one premium). The employee must be enrolled in voluntary group term life insurance to select coverage for their child(ren).

BENEFICIARY DESIGNATIONS

You are encouraged to update your life insurance beneficiaries when you experience a change in family status such as marriage, death, divorce, etc. You may change your beneficiaries at any time. Please contact Benefits-HR.

FLEXIBLE SPENDING ACCOUNTS (FSAs)

The employer-sponsored Flexible Spending Accounts (FSA) program offered by the City of Fort Lauderdale is administered by Benefits Outsource, Inc. (BOI), located in Davie, Florida. Employees have the option of participating in the Health Care or Dependent Care account, or both. Participants do not carry over balances from the previous year. **You MUST re-enroll during open enrollment.**

An FSA allows you to reduce your taxable income by setting aside pre-tax dollars to pay for eligible health care and dependent care expenses approved by the Internal Revenue Code (IRC). Eligible expenses covered are for you and all of your dependents, even if they are not covered under your primary health plan(s). It is important that you only allocate dollars for predictable health and dependent care expenses. Any unused FSA funds at the end of the grace period, March 15, 2021 (for 2020 Plan Year), will be forfeited, also called the use-it-or-lose-it rule. You must file for reimbursement no later than March 30, 2021 (for 2020 Plan Year).

HEALTH CARE FSA (ANNUAL MAXIMUM ELECTION 2,700)

The maximum election for Health Care FSA is $2,700. This is an annual benefit that allows participation when an election is made during the open enrollment period. Nonetheless, newly hired employees may also participate and enroll within the initial enrollment eligibility period. A big perk with the Healthcare FSA is that it is pre-funded, meaning that the full annual election amount is accessible at the beginning of the plan year. Eligible out-of-pocket expenses for reimbursement relate to any health plan (i.e., medical, dental and vision). Eligible expenses include copays, deductibles, co-insurance, eyeglasses, dental care, and certain medical supplies. (Over-the-counter medications are eligible with a doctor's prescription. View the full list of eligible expenses at www.irs.gov/publications/p502/.) The benefits debit card provided upon enrollment lets you easily access all of your account so there are no out-of-pocket costs.

Please note: Employees enrolled in the Consumer Driven Health Plan (CDHP) medical plan should first exhaust their Health Reimbursement Account (HRA) for any eligible medical expenditures BEFORE using their Health Care FSA funds.

DEPENDENT CARE FSA (ANNUAL MAXIMUM ELECTION $5,000)

A Dependent Care FSA is also a pre-tax account established for employees to benefit tax-wise while paying for eligible daycare expenses in order to work. The IRS limits annual contributions to $5,000 annually if "married filing joint tax returns" or "single head of household" or $2,500 for "married filing separately." Qualified dependents are:

- Children under the age of 13 who share the same residence with you, or
- Your spouse or qualifying child or relative who is physically or mentally unable to care for him/herself who shares the same residence with you whose income is less than the federal exemption amount

Unlike the Health Care FSA, with the Dependent Care FSA, you can only spend up to the amount that has been deducted from your paycheck. With the swipe of your benefits debit card, you can access your funds; otherwise, you can submit manual claims for reimbursement.

ELIGIBLE EXPENSES INCLUDE:

- Before school or after school care (other than tuition)
- Custodial care for dependent adults
- Licensed day care centers
- Nursery schools or preschools
- Placement fees for a provider, such as au pair
- Day camp, nursery school or a private sitter
- Late pick-up fees
- Summer or holiday day camp (not sleepover)

TAX SAVINGS ACCOUNTS

ANNUAL MINIMUM ELECTION $260 – HEALTH AND DEPENDENT CARE FSA

The minimum employee annual contribution for Health and/or Dependent Care FSA is $260. The minimum election mitigates the employee risk and allows you to experience the pre-tax savings of this worthwhile employer-sponsored benefit.

CLAIM REIMBURSEMENT

Your benefits debit card lets you easily access the Healthcare FSA and Dependent Care FSA funds. Employees who re-enroll in the FSA account will continue to use the same debit card up to the card's expiration date. A new debit card will be issued to new enrollees and to those whose previous debit card expired. Payments are automatically withdrawn from your account(s). One card can access all of your benefit accounts. If manual submission of a claim is required, you may submit itemized receipts to BOI via email, fax, mail and online portal upload. Disbursements of weekly claim reimbursements are done via ACH/direct deposit or manual check.

FSA ADMINISTRATIVE SERVICES INFORMATION

Benefits Outsource, Inc.
5599 South University Drive, Suite 201
Davie, FL 33328

To contact BOI with any questions, please call their customer service department Monday – Friday from 9 a.m. to 5:30 p.m. at 954-680-7626 or 1-888-877-2780 (toll free).

For 24/7 online access to your account, logon to www.mywealthcareonline.com/boi. To submit manual claims, you may upload documentation using BOI's online portal, email benefits@boibenefits.com or fax to 954-680-7630.

457(b) DEFERRED COMPENSATION

The 457(b) Deferred Compensation Plan is tax-deferred and may be used to supplement your defined contribution or defined benefit plan and social security benefits during retirement. The 457(b) Deferred Compensation Plan allows for both pre-tax and after-tax contributions. Employees can select which option best suits their long-term financial needs. The City offers two deferred compensation plan providers, ICMA-RC and Nationwide Retirement Solutions. Contributions to a tax-deferred plan will lower taxable income in the year contributed. After-tax plans do not lower taxable income in the year contributed. All income taxes are deferred until you withdraw or receive a distribution after separation from service. You may contribute to either or both providers. Both ICMA-RC and Nationwide offer a wide selection of investment options ranging from conservative to aggressive. Nationwide and ICMA-RC cannot provide tax advice; however, each company has a professional investment advisory program that you can elect to help manage your accounts.

457(b) Deferred Compensation Features

- If you experience an unforeseeable emergency, you may be able to withdraw funds from your account as permitted by Internal Revenue Code Section.
- The plan allows participants to apply for loans of up to 50% of their account balance, not to exceed $50,000.
- Does not include a 10% tax penalty for early distributions/withdrawals upon separation of employment prior to age 59½, as is typical in 401(a) plans.
- Upon separation from employment, you may keep the funds invested in the accounts or roll them over to another tax-qualified retirement plan. You are required to begin receiving minimum distributions the latter of April 1 following the calendar year in which you turn 70½ or April 1 following the year in which you retire (if 70½).

457(b) Maximum tax year contributions (as of posting):

- $19,000 normal limit
- $25,000 if age 50 or older as year-end
- $38,000 if you qualify for pre-retirement catch-up contributions

Benefits that Go Together

A Roth IRA and 457(b) Deferred Compensation Plan go together; use both to reach your savings goals with added tax benefits and flexibility.

- For different savings goals: Additional retirement income, health care, a home purchase, college education, emergencies
- For different tax benefits: You can get a tax benefit now when you contribute to your 457(b) plan and a tax benefit later when you withdraw from your Roth IRA. And, if you retire early you can withdraw from your 457(b) plan without penalties.

MATCH YOUR ROTH IRA WITH YOUR 457(b) PLAN

Tax-free withdrawals/distributions, including earnings, are tax- and penalty-free if you have:

- Owned a Roth IRA for at least five years, as defined by the IRS; and
- A qualifying event, such as age 59½, a "first-time" home purchase, disability or death.

Otherwise, income and penalty taxes may apply to the withdrawal of earnings, but contributions can be withdrawn at any time without taxes or penalties. There are no IRS required minimum distributions, so loved ones can receive money you do not need tax free.

Maximum annual Roth contributions (as of posting):
Up to $6,000, or $7,000 if age 50 or older, as of the current year-end and if your IRS Modified Adjusted Gross Income is less than:

- $122,000 for individual filers ($122,000 - $137,000 to make partial contributions)
- $193,000 for married joint filers ($193,000 - $203,000 to make partial contributions)

LEARN MORE

ICMA-RC:

IRA: www.icmarc.org/ira
457(b) plan: www.icmarc.org/fortlauderdale.html
Contact your ICMA-RC representative at yflores@icmarc.org

NATIONWIDE RETIREMENT SOLUTIONS:

www.nrsforu.com
Contact your Nationwide Retirement solutions representative at pinzona@nationwide.com and schwara5@nationwide.com.

LONG-TERM DISABILITY

CIGNA

CITY PAID LONG-TERM DISABILITY INSURANCE

The City provides Long-Term Disability (LTD) insurance, at no cost, to benefit-eligible employees through Cigna. The LTD benefit pays the employee a percentage of monthly earnings if the employee becomes disabled due to an illness, non-work related accident, or injury. Eligible employees are automatically enrolled in this coverage.

LTD Plan Summary

Eligibility	**All active, full-time employees of the City covered under the 401(a) Defined Contribution Retirement Plan, regularly working a minimum of 40 hours per week.**
Eligibility Waiting Period	First of month following the first day of employement
Monthly Benefit	60% to $15,000
Minimum Benefit	Greater of $100 or 10% of benefit
Benefit Waiting Period	180 days
Definition of Disability	24 months own occupation
Definition of Covered Earnings	Employee's annual wage or salary excluding bonuses, commissions, overtime pay, and extra compensation.
Accumulated Sick Leave	Not included in benefit waiting period
Maximum Benefit Duration	Social Security Normal Retirement Age (SSNRA)
Employer Contribution	100%
Survivors Benefits	3 months lump sum
Pre-Existing Condition Limitation	3 months prior/12 months insured

For additional policy information go to **www.fortlauderdale.gov/benefits** or on LauderShare at **www.fortlauderdale.gov/benefits**.

VOLUNTARY BENEFITS

The City offers Voluntary Benefits that are administered by FBMC Benefits Management to all eligible active employees. These are optional benefit plans that are paid 100% by employees and typically have the advantage of preferred rates, not available to individuals on their own, and the convenience of paying premiums through payroll deduction.

Employees can only add voluntary benefits during open enrollment. Newly eligible employees have 30 days from their eligibility date to enroll in voluntary benefits. The effective date for all voluntary benefits is the first of the month following 30 days of the voluntary benefits application being signed. Example: A new hire with a hire date of October 8, 2019 enrolled in and signed the voluntary benefits application on October 26, 2019 making their voluntary benefits effective December 1, 2019.

Aflac Plans:

- **Group Hospital Indemnity Insurance, Aflac** (Post-Tax): Provides financial assistance when you are confined to a hospital.
- **Group Accident Insurance, Aflac** (Pre-Tax): Provides financial benefits for covered accidents.
- **Short Term Disability Insurance, Aflac** (Post-Tax): Provides financial benefits in the event of a qualified disability.
- **Group Critical Illness Insurance, Aflac** (Pre-Tax): Provides benefits when diagnosed with a covered critical illness.

If you are a newly eligible employee who would like to enroll in any of the voluntary Aflac benefits, you must speak with a Professional Benefits Counselor/Enroller. Professional Benefits Counselors/Enrollers will be available for telephone appointments. During your appointment, your Professional Benefits Counselor/Enroller will:

- Provide education on voluntary benefits offered and assist you with making benefits decisions to best meet your needs
- Answer any questions you may have about offered voluntary benefits
- Assist you with making your voluntary benefits elections

A Professional Benefits Counselor/Enroller will contact newly eligible employees. You may also schedule a telephonic appointment at http://cofl.fbmc.com or by calling 1-866-998-2915.

ARAG Legal Insurance Plans:

- **Legal Insurance, ARAG** (Post-Tax): Provides attorney fees for most covered legal matters within the plan limits.

If you are a newly eligible employee who would like to enroll in voluntary ARAG Legal benefit, you must complete a benefits enrollment form.

FLORIDA PREPAID COLLEGE TUITION: Florida Prepaid you to save for your dependent's college education through payroll deductions. You may obtain more information about the program online at www.myfloridaprepaid.com or by calling 1-800-552-4723.

LOANS AT WORK: This voluntary loan program will provide City employees with the opportunity to apply for unsecured loans for health care expenses or any other needs up to $5,000 (capped at 20% of net take-home pay) to be repaid through payroll deductions.

WHO IS ELIGIBLE TO PARTICIPATE IN GROUP COVERAGE?

EMPLOYEES

- Full-time employees (both regular full time and temporary full time) are eligible to participate in all group benefits. Variable hour employees, such as part-timers who satisfy the criteria under the Affordable Care Act, are eligible to participate in any of the City's medical plans for the 2020 plan year.
- New hires are eligible for benefits the first day of the month following 30 days from their hire date. The coverage effective date for selected benefits is the same as the eligible date as long as Benefits Section, HR receives the electronic enrollment requirements via NeoGov no later than 30 days from hire date (must be actively working for life insurance to be effective). Enrollment requests after the 30 day time limit will not be processed and you cannot re-apply until the next open enrollment, unless you experience an Internal Revenue Code (IRC) Section 125 qualifying event or Special Enrollment Rights. You may contact Benefits Section, HR at 954-828-5160 if you do not have access to a computer. **Social Security numbers and documentation to support dependent status must be provided to Benefits Section, HR for all dependents**. Please visit www.fortlauderdale.gov/benefits or Laudershare at www.fortlauderdale.gov/laudershare.
- Police employees represented by the Fraternal Order of Police (FOP) are eligible for medical, dental and vision benefits through the FOP ONLY and may participate in the City's life, Health Care and Dependent Care Flex Spending Accounts and voluntary benefits.

DEPENDENTS

Who are my eligible dependents and what documentation is required as proof of eligibility?

If you enroll for medical, dental, or vision insurance you may also enroll your eligible dependents (identified below). The type of documentation acceptable, as proof of dependent eligibility, is identified in parenthesis. Documentation must be provided at the time you enroll via attachment in NeoGov or by submitting the document(s) to Benefits Section, HR. If the documentation is not readily available, please complete the online enrollment (active employees) or change request form (retirees) and follow-up with the documentation as soon as it becomes available. **Your enrollment request will not be processed without the supporting documentation.** Please remember to write your employee ID number on each document submitted. If both parents are enrolled for benefits as employees through the City, children may not be enrolled for coverage under both parents.

- Spouse, if she/he is not also a benefits-eligible City of Fort Lauderdale employee **(official marriage certificate)**
  Ex-spouse is not eligible for coverage under your insurance
- Domestic partner (if she/he is not also a City of Fort Lauderdale employee eligible for benefits) as established by the City **(Affidavit of Domestic Partnership)**
- Your biological child, legally adopted child or a child placed in the home for adoption in accordance with applicable state and federal laws **(official birth certificate, copy of official legal documents proving the status)**
- Child(ren) of your domestic partner, unless covered by a spouse/domestic partner who also works for the City of Fort Lauderdale **(copy of official birth certificate showing the domestic partner as the parent)**
- Your child, if permanently physically and/or mentally disabled **(and not an eligible City employee)**, may be covered indefinitely beyond the limiting age as long as acceptable proof of the disability is provided to the plans. **(The health plan will request medical proof of the disability)**
- Specified dependent child or foster child placed in your home **(copy of the executed court order)**
- A grandchild up to age 18 months if born while your child is covered under the plan (Florida Statute 627.6575) and the parent remains covered under the plan **(copy of birth certificate)**
- The Affordable Care Act permits married or unmarried dependent children to be covered under the medical plans to the last day of the calendar year that they reach the age of 26. An unmarried dependent child may be covered for medical beyond the end of the calendar year in which he/she turns age 26 to age 30, if the criteria established by Florida Statutes are satisfied. Dependent children enrolled for dental, vision and life insurance coverage are eligible to the end of the calendar year in which they turn age 26.
- Your foster child, if placed in your home prior to age 18 **(proof of placement by the Department of Children and Families or the foster care program of a licensed agency)**

What are the criteria for dependent children ages 26-30 (end of calendar year) to be eligible for group medical coverage?

- Florida Statute Chapter 627.6562 stipulates that the child must be (a) unmarried without any dependents, (b) a resident of Florida or a full-time/part-time student and (c) is not provided coverage or is not a covered person under any other group medical insurance policy or individual medical benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act. A certification form must be completed annually during open enrollment.
- Employees enrolling a new dependent child age 26+ must provide supporting documentation that the child was continuously covered by other creditable coverage without a gap in coverage of more than 63 days.

PRE-TAX PREMIUM/IMPUTED INCOME

What is pre-tax premium?

Pre-tax premium is an insurance contribution deducted from your paycheck before you pay any taxes. Premium contributions for medical, dental, vision, health care and dependent care FSAs are deducted through a Cafeteria Plan established under Internal Revenue Code (IRC) Section 125 and the City's Flexible Benefits Plan document. Due to IRC Section 125 rules, mid-year pre-tax premium changes may only be processed if the employee satisfies a qualifying event as permitted by the IRC Section 125, and the City's Plan document, or exercises a HIPAA Special Enrollment Right and submits a timely request.

Are premiums for adult children ages 26 to 30 and domestic partners/dependent children of domestic partners deducted pre-tax?

Generally, no. Premiums attributable to dependent children ages 26 to 30 are deducted post-tax unless they meet the definition for tax-qualified dependent under the Internal Revenue Code. Premiums attributable to domestic partners, and the children of domestic partners are deducted post-tax unless it is established that they are qualified tax dependents as defined by the Internal Revenue Code. To have premiums payroll deducted pre-tax, the employee must also complete the Domestic Partner Certification of Dependent Status Form and must re-certify annually during open enrollment. The required forms are included under the Forms section on the Employee Benefits web page at www.fortlauderdale.gov/benefits and LauderShare at www.fortlauderdale.gov/laudershare.

What is imputed income for health insurance?

The Internal Revenue Code (IRC) allows employees to pay "tax-free" health insurance subsidies for themselves and their eligible dependents as defined under IRC provisions but generally excludes the amount attributable to dependent children after the end of the year in which they turn age 26, domestic partners and children of domestic partners. This excluded amount is referred to as imputed income. The City does not subsidize premiums for adult children ages 26 to 30 years old. Please see the life insurance section for imputed income related to City paid life insurance.

IRC SECTION 125 CHANGE IN STATUS QUALIFYING AND OTHER PERMITTED EVENTS

What mid-year (outside of the annual open enrollment period) qualifying events allow me to add or delete dependents?

The health plans are governed by Internal Revenue Code Section 125 rules and the City's Flexible Benefits Plan document, which permits mid-year plan changes (example to add or delete dependents) only if certain qualifying events are experienced by the employee or dependent. Therefore, a participant may not revoke any elections made, outside of the annual benefits open enrollment period, **except** as illustrated in the following qualifying events or Special Enrollment Rights:

- A change in the participant's legal status, including marriage, divorce, death of the participant's spouse, domestic partnership status (post-tax, unless a qualified tax dependent as defined by the Internal Revenue Code and the employee completes a Domestic Partner Certification of Dependent Status Form)
- A change in the number of dependents that the participant has for federal income tax purposes due to events such as birth, adoption, placement for adoption or death
- Termination or commencement of employment of the participant, spouse, domestic partner (post-tax unless a qualified tax dependent under the Internal Revenue Code), or dependent of the participant
- A reduction or increase in the hours of employment such as a switch between part-time and full-time status, going on an approved unpaid leave of absence (LOA)/Family Medical Leave Act (FMLA) or returning from an approved LOA/FMLA
- An event that causes the participant's dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age
- A court order or judgment, decree, or change in legal custody, including a qualified medical child support order
- Entitlement to/or loss of Medicare eligibility, entitlement to Medicaid
- Entitlement to Premium Assistance under State Medicaid or Children's Health Insurance Program (CHIP), OR loss of eligibility for State Medicaid or CHIP (60 days allowed to exercise special enrollment rights after termination of Medicaid or CHIP coverage)
- Differences in the open enrollment periods between the City and another employer affecting the participant's spouse or dependent
- Significant increases in plan costs
- Significant curtailment in plan benefits
- Special Enrollment Rights: If an employee becomes eligible to exercise any Special Enrollment Rights, he/she may change election for the balance of the plan year and file a new election which corresponds with the exercise of those rights. For more information on Special Enrollment Rights, please click on the Cigna image on the Benefits web page to review the certificates of coverage.

What is the consistency rule governing change in status requests?

IRC Section 125 requires that any change in status requests processed must be consistent with the qualifying event. For example, if the employee gets a divorce, it would be a qualifying event to delete the ex-spouse, but not to add existing dependent children who were not

on the employee's plan. Another example is the event of a deceased spouse. It would be a qualifying event to delete the deceased spouse and add the existing dependents, if they were enrolled under the spouse's health plan, within 30 days from the date of death.

How do I make a change to my medical/dental/vision/life insurance plan outside of the annual open enrollment and what is the time frame?

To make a change in your medical, dental or vision plan, or life insurance outside of the annual open enrollment, ACTIVE employees must complete a Benefits Election Change Form and Flex Change in Status Form and submit it to the Benefits Section, HR no later than 30 days from the event (60 days for newborns/adoptions/placement for adoption/entitlement or loss of Medicaid/CHIP and other events noted in IRC section 125). Retirees must complete a Benefits Election Change Form and a Flex Change in Status Form and submit them to Benefits Section, HR. These forms may be downloaded from www.fortlauderdale.gov/benefits or obtained from the Benefits Section, HR. Do not delay submitting the completed change forms while you gather the supporting documentation. Change requests must be completed within the specified time frames. You must then follow up with submitting the supporting documentation to Benefits Section, HR as soon as it becomes available, but no later than 30 days after the event. The types of documentation required to support the change in status are on the Change in Status Form. Changes between health plans are generally not allowed.

When do requested changes become effective?

Open enrollment changes become effective January 1 of the following year with the exception of life insurance increases which are effective subject to approval from Standard Insurance Company. Outside of the open enrollment period, changes generally become effective the first day of the month following receipt of the change request if provided within 30 days from the date of the event (60 days for newborns/adoptions/placement for adoption/ entitlement to State Medicaid/CHIP or entitlement to CHIP).

When do changes to add a new dependent become effective?

Changes to add a new dependent become effective the first day of the month following, or coincident to, timely receipt by Benefits Section, HR, of the request, with the exception of birth, adoption or placement for adoption which become effective as of birth or the earlier of (a) adoption or (b) placement for adoption.

Payroll changes to add newborn child(ren) are processed in accordance with Florida Statute 641.31(9). If the change request is completed within 30 days of birth, the premium is waived for the first 30 days from birth. If the change request is completed after the first 30 days, but within 60 days of the qualifying event (birth, adoption or, placement for adoption), the new premium will be charged retroactive to the date of the qualifying event.

What if I submit a late request for a change in status qualifying event?

If the request is submitted beyond the required time frames, the change will not be processed. If the request is to delete an ineligible dependent, you will be responsible financially for any claims incurred by that ineligible dependent but the premium changes, if applicable, will not be processed. Late requests to add new dependents will not be processed. You will need to make the change during the annual benefits open enrollment or if you exercise an allowable HIPAA Special Enrollment Right.

CANCELLATION

May I cancel coverage outside the annual benefits open enrollment?

Employees may request cancellation of coverage during the year as permitted by Florida Statute. However, for pre-tax benefits, if there is not an IRC Section 125 qualifying event, pre-tax premium payroll deductions will continue through the end of the current plan year. If you opt-out or cancel your coverage you may not reapply (a) until the annual benefits open enrollment period, which takes place in the fall of each year, or (b) if you may exercise a HIPAA Special Enrollment Right. Requests to cancel post-tax benefits during the year will be processed prospectively without a penalty. Applications to re-enroll for life insurance benefits are subject to evidence of insurability.

BENEFICIARY DESIGNATIONS

May I update my beneficiaries at any time?

Yes. If enrolled for life insurance, you are strongly encouraged to review your beneficiaries and update, if necessary, when you experience a change in status such as divorce, marriage, death, or any other changes. You are also encouraged to list contingent/secondary beneficiaries in the event your primary beneficiary(ies) predeceases you. Simply download the Group Term Life Beneficiary Designation Form from the City's Employee Benefits web page, complete it and drop it off, fax, or mail to Benefits Section, HR.

Where may I find information on life insurance benefits and provisions?

Review the certificates of coverage at www.fortlauderdale.gov/benefits or on LauderShare at www.fortlauderdale.gov/laudershare or contact Standard Insurance Company at 1-888-937-4783.

HEALTH REIMBURSEMENT ACCOUNT (HRA)

What is an HRA?

An HRA is an employer-funded, tax-qualified spending account that may be used to pay for qualified medical expenses such as deductibles and coinsurance for covered medical expenses and prescription drugs.

Do all employees enrolled in the medical plans have an HRA account funded by the City?

No. HRA funding is only available to employees and their tax-qualified dependents enrolled for the Consumer Driven Health Plan (CDHP). Employees may not access funds remaining in the account upon separation of employment since the account is not portable. Retirees and non-tax qualified dependents (i.e. adult child dependents, domestic partners and domestic partner's child(ren)) are not eligible for HRA funding. These dependents can be insured

and receive coverage as any other insured but will have their own deductible and out-of-pocket maximum that is separate from the employee and tax-qualified dependents. The employee will not receive the portion of the HRA attributable to coverage for a domestic partner, their dependents or an Adult Child Dependent.

How much HRA funding does the City provide for eligible Consumer Driven Health Plan (CDHP) participants for the plan year?

- Employee only = $750
- Employee + one tax-qualified dependent = $1,000
- Employee + two or more tax-qualified dependents = $1,500
- The funding is prorated for enrollments after January 1.

Is there a separate ID card for the HRA?

No. The Cigna ID card is presented to access the HRA funding.

How do I keep track of the funds remaining in my HRA or obtain more information?

You may keep track of your HRA balance by reviewing Explanation of Benefits (EOB) statements received, by logging on to www.myCigna.com, reviewing quarterly HRA statements received, or by contacting Cigna's customer service 24/7 toll-free at 1-800-244-6224. You may also review the Cigna summary plan descriptions on the Employee Benefits web page.

May the funds in my HRA be rolled over to another calendar year?

Yes; however, this is subject to changes in IRS guidelines and City policy.

COBRA

What is COBRA?

- COBRA is the federal law that requires most group health plans, including Health Care Flex Spending Accounts, to give employees, their covered dependents and qualified beneficiaries the opportunity to continue their group health benefits when there is a "qualifying event" (i.e., termination of employment, retirement, divorce, death of employee, etc.) that would result in a loss of coverage under an employer's plan. Continuation coverage for each qualified beneficiary must be the identical coverage that the plan offers to active employees and covered dependents. COBRA rights may be exercised independently for each qualified beneficiary.
- The following individuals do not have the right to independently elect COBRA: domestic partners, grandchildren and/or stepchildren (unless adopted by the employee). However, if the employee elects COBRA continuation coverage for themself, they may also cover their dependents even if they are not considered qualified beneficiaries under COBRA. Such individuals' coverage will terminate when the employee's COBRA continuation coverage terminates.
- The employee or family member must provide written notice to Benefits Section, HR within 60 days of the event when a covered spouse loses eligibility due to divorce or a dependent child loses eligibility.
- The law specifies the time frames within which qualified beneficiaries must be notified, be allowed to elect continuation coverage and make payments. The cost to qualified beneficiaries may not exceed 102% of the premium equivalent cost of insurance for the active group.

How will I and my qualified beneficiaries be notified of my COBRA rights?

The City has contracted with a Third Party Administrator (TPA), currently Benefits Outsource, Inc. (BOI), to administer the COBRA provisions, provide notification within the time frames specified by the federal law and to perform the accounts receivable functions for qualified beneficiaries who elect continuation. The City provides the TPA with information pertaining to new enrollees and employees losing group coverage due to termination of employment and other known qualifying events.

Where may I obtain more information on COBRA?

Go to the BOI posting at www.fortlauderdale.gov or contact the City's COBRA Administrator, BOI, at 954-680-7626 or toll-free at 1-888-877-2780.

APPROVED UNPAID LEAVES OF ABSENCE (LOA)/THE FAMILY AND MEDICAL LEAVE ACT FMLA

How do I maintain my group benefits while on unpaid leave and FMLA?

Going on an approved unpaid LOA or FMLA leave is considered a qualifying event that allows you to make changes to your coverage consistent with the event. For example, you may delete dependents or cancel coverage within 30 days of being in an unpaid LOA or FMLA leave. Since you will not receive a paycheck while on unpaid leave, the premiums to cover your plan elections cannot be payroll deducted. You must take steps to ensure there is no disruption in your coverage. Before you miss your first paycheck, please contact Benefits Section, HR for instructions on how much to pay, the frequency of payments and other pertinent information.

2020 IMPORTANT NOTICE FROM THE CITY OF FORT LAUDERDALE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE TO ACTIVE EMPLOYEES, RETIREES AND DEPENDENTS PARTICIPATING IN THE FOLLOWING CITY-SPONSORED HEALTH PLANS:

Cigna Open Access Plus In-Network 1 (OAPIN1, aka HMO1) and Cigna Open Access Plus In-Network 2 (OAPIN2, aka HMO2) and Consumer Driven Health Plan (CDHP)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of Fort Lauderdale and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available to everyone with Medicare in 2006. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium

2. The City of Fort Lauderdale has determined that the prescription drug coverage under OAPIN1 (HMO1), OAPIN2 (HMO2) and Consumer Driven Health Plan (CDHP) are, on average, expected to pay out as much as standard Medicare prescription drug coverage pays for all plan participants and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you may keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare drug plan?

If you decide to join a Medicare drug plan, your current City of Fort Lauderdale coverage will not be affected.

For those individuals who elect Part D coverage and elect to drop coverage under the City of Fort Lauderdale's plan, coverage will end for the individual and all covered dependents, etc. See the Centers for Medicare and Medicaid Services (CMS) Disclosure of Creditable Coverage to Medicare Part D Eligible Individuals Guidance (available at **http://www.cms.hhs.gov/CreditableCoverage**), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

Your current City of Fort Lauderdale coverage pays for other medical expenses in addition to prescription drug benefits. If you do decide to join a Medicare drug plan and drop your current City of Fort Lauderdale medical plan, which includes prescription drug benefits, please be aware that you (if actively employed) and your dependents may not be able to get this coverage back until the next annual benefits open enrollment period, which has an upcoming effective date of January 1. Retirees who drop their current City of Fort Lauderdale plan, which includes prescription drug coverage, must be aware that they will not be able to get this coverage back at a later date.

When will you pay a higher premium (penalty) to join a Medicare drug plan?

You should also know that if you drop or lose your current coverage with the City of Fort Lauderdale and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage:

Contact the office listed below for further information and refer to the certificates of coverage issued by the prescription drug provider. NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through the City of Fort Lauderdale changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number)
- For personalized help, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov** or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	**October 14, 2019**
Name of Entity/Sender:	**City of Fort Lauderdale**
Contact-Position/Office:	**Benefits Section, Human Resources**
Address:	**100 North Andrews Avenue, 3rd Floor Fort Lauderdale, FL 33301**
Phone Number:	**954-828-5160**

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact BENEFITS SECTION, HR.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name CITY OF FORT LAUDERDALE		4. Employer Identification Number (EIN) 59-6000319
5. Employer address 100 N. ANDREWS AVENUE		6. Employer phone number 954-828-5160
7. City FORT LAUDERDALE	8. State FL	9. ZIP code 33301
10. Who can we contact about employee health coverage at this job? BENEFITS MANAGER		
11. Phone number (if different from above)	12. Email address healthyliving@fortlauderdale.gov	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:
    All full-time employees and part-time employees who satisfy the criteria under the Affordable Care Act (ACA).
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:
    Spouses, domestic partners, dependent children of employees up to the end of calendar year in which they turn age 26 and those who satisfy the guidlines under Florida Statute (FS627.6562)
  - ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Note: Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid–year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

CITY OF FORT LAUDERDALE NOTICE REGARDING COLLECTION, USE, AND DISCLOSURE OF SOCIAL SECURITY NUMBERS

The collection of social security numbers by the City of Fort Lauderdale ("City") is either specifically authorized by law or imperative for the performance of the City's duties and responsibilities as prescribed by law and the Florida Constitution. The following list identifies the purposes for which social security numbers may be collected, used, or disclosed, the relevant legal authority, and whether collection of the social security number for the stated purpose is mandatory or authorized.

- For employment eligibility, reports to the Internal Revenue Service, and income tax withholding, including for W-2's, W-4's, and I-9's. [Collection mandated by 26 U.S.C. §6051, 26 C.F.R. §31.6011(b)-2, 26 U.S.C. §3402, 26 C.F.R. §31.3402(f)(2)-1, 31 C.F.R. §31.3402(f)(5)-1, 8 U.S.C. §1324a, 8 C.F.R. §274a.2, 26 C.F.R. §31.6051-1, and 26 C.F.R. § 301.6109-1. Disclosure: 26 U.S.C. §6051, 26 C.F.R. §6051-1, §119.071(5)(a)6, Fla. Stat.];
- For reports to the Social Security Administration. [Disclosure: 26 C.F.R. §31.6051-2, §119.071(5)(a)6, Fla. Stat.];
- For administration of the City's health benefits, pension fund, deferred compensation plan, and defined contribution plan, [Disclosure: §119.071(5)(a)6, Fla. Stat.];
- For income deduction notices for child support, alimony, and child support enforcement. [Collection authorized by §§61.1301(2)(e) and 61.13, Fla. Stat. Disclosure: 42 U.S.C. §653a(b), §119.071(5)(a)6, Fla. Stat.];
- For unemployment compensation benefits. [Disclosure: §119.071(5)(a)6, Fla. Stat.];
- For reports of worker's compensation injury or death. [Disclosure: §§440.185, and 119.071(5)(a)6, Fla. Stat.];
- For worker's compensation petitions for benefits and responses. [Collection authorized by §60Q-6.103, Florida Administrative Code. Disclosure: §60Q-6.103, Florida Administrative Code, and §119.071(5)(a)6, Fla. Stat.];
- For notices of tort claim. [Collection mandated by §768.28(6), Fla. Stat.];
- For verification of identity, background investigations and criminal history checks. [Disclosure: §119.071(5)(a)6, Fla. Stat.];
- The social security number may be disclosed to facilitate the direct deposit of funds to a payee's account. [§119.071(5)(a)6, Fla. Stat.]
- The social security number may be disclosed if it is expressly required by federal or state law or a court order. [§119.071(5)(a)6, Fla. Stat.]
- The social security number may be disclosed if the individual expressly consents in writing to the disclosure of his or her social security number. [§119.071(5)(a)6, Fla. Stat.]
- The social security number may be disclosed if the disclosure is necessary for the City to perform its duties and responsibilities. [§119.071(5)(a)6, Fla. Stat.]
- The social security number may be disclosed if the disclosure is made to comply with the USA Patriot Act of 2001, Pub. L. No. 107-56, or Presidential Executive Order 13224. [§119.071(5)(a)6, Fla. Stat.]
- The social security number may be disclosed if the disclosure is made to a commercial entity for the permissible uses set forth in the federal Driver's Privacy Protection Act of 1994, 18 U.S.C. ss. 2721 et seq.; the Fair Credit Reporting Act, 15 U.S.C. ss. 1681 et seq.; or the Financial Services Modernization Act of 1999, 15 U.S.C. ss. 6801 et seq., provided that the authorized commercial entity complies with the requirements of Fla. Stat. § 119.071(5). [§119.071(5)(a)6, Fla. Stat.]

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in Florida, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www .insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa .dol.gov or by calling toll-free 1-866-444-EBSA (3272).

For further information on eligibility in Florida:

FLORIDA - Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

SPECIAL ENROLLMENT RIGHTS

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision." Special enrollment rights apply when you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program) - If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll your self and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program - If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption - If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents . However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program - If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact:

City of Fort Lauderdale
Benefits Section, 3rd Floor
Human Resources
100 North Andrews Avenue
Fort Lauderdale, FL 33301

NOTES

NOTES

CITY OF FORT LAUDERDALE

Benefits Section | Risk Management Division | Human Resources
City Hall • 100 N. Andrews Avenue • Fort Lauderdale, FL 33301
(954) 828-5160 • www.fortlauderdale.gov/benefits • healthyliving@fortlauderdale.gov

BENEFITS DIRECTORY

MEDICAL AND DENTAL		
• CIGNA Medical and Dental	www.cigna.com	1-800-244-6224
• Personal CIGNA Web Portal	www.mycigna.com	
• Employee Assistance Program (EAP)	www.cignabehavioral.com (Employer ID: cofl)	1-877-622-4327 (24/7)
• Kerri Holden, CIGNA Onsite Wellness Coordinator		954-652-1306 Fax: 1-860-847-5126
VISION		
• UnitedHealthcare Vision	www.myuhcvision.com	1-800-638-3120 Fax: 1-248-733-6060
CITY HEALTH AND WELLNESS CENTER		
• Marathon Health (Administrator)	www.marathon-health.com/MyPhr/login	1-754-206-2420 Fax: 954-867-5583
LONG-TERM DISABILITY		
• Cigna Long-Term Disability Cigna	www.cigna.com	1-888-842-4462 1-866-561-8421
LIFE INSURANCE		
• Standard Insurance Company	www.standard.com	1-888-937-4783 Fax: 1-971-321-5994
INCOME PROTECTION		
• Aflac Short-Term Disability Insurance	http://cofl.fbmc.com	1-800-992-3522
• All Other Aflac Products (Group Accident, Group Critical Illness Advantage and Group Hospital Indemnity Insurance)	http://cofl.fbmc.com	1-800-433-3036
FSA ADMINISTRATOR		
• Health Care FSA • Dependent Care FSA	www.mywealthcareonline.com/boi www.mywealthcareonline.com/boi	954-680-7626 Fax: 954-680-7630
LEGAL SERVICES		
• ARAG Legal	http://cofl.fbmc.com	1-800-247-4184
FLORIDA PRE-PAID COLLEGE TUITION		
• Florida Prepaid College Tuition	www.myfloridaprepaid.com	1-800-552-4723 Fax: 1-850-309-1766
DEFERRED COMPENSATION / LOANS		
• ICMA-RC	www.icmarc.org	1-800-669-7400 Fax: 1-202-682-6439 / Attn: WMT
• Nationwide	www.nrsforu.com	1-877-677-3678 Fax: 1-877-677-4329
• BMG Loans at Work	www.loansatwork.com	1-800-316-8507

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♻ Printed on recycled paper.